No. 300
10-48

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED FEB 7 1953

State File No. 436

BIRTH NO. 593 REG. DIST. NO. 43 PRIMARY REG. DIST. NO. 3007 Registrar's No. 28

1. PLACE OF DEATH
a. COUNTY: Butler
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Poplar Bluff
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Lucy Lee Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Mo.
b. COUNTY: Ripley
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Naylor 6910
d. STREET ADDRESS (If rural, give location): 1

3. NAME OF DECEASED (Type or Print)
a. (First): Linda
b. (Middle): Sue
c. (Last): Laughlin

4. DATE OF DEATH (Month) (Day) (Year): Jan 5 1953

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Infant 0
8. DATE OF BIRTH: Jan 4 1953
9. AGE (In years last birthday): IF UNDER 1 YEAR Months: Days: 1 IF UNDER 24 HRS. Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Lucy Lee Hospital
12. CITIZEN OF WHAT COUNTRY?: 0

13a. FATHER'S NAME: Wayne Laughlin
13b. MOTHER'S MAIDEN NAME: Jean Martin
14. NAME OF HUSBAND OR WIFE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown):
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT'S SIGNATURE OR NAME: Wayne Laughlin
ADDRESS: Naylor, Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Prematurity — INTERVAL BETWEEN ONSET AND DEATH: 24 hr.

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c) 776 X

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* Jan. 4, 1953, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE: W M Phillips Jr (Degree or title) MD
23b. ADDRESS: Poplar Bluff
23c. DATE SIGNED: 1/10/53

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 1/6/53
24c. NAME OF CEMETERY OR CREMATORY: Naylor
24d. LOCATION (City, town, or county) (State): Naylor Missouri

DATE REC'D BY LOCAL REG.: Jan 26 1953
REGISTRAR'S SIGNATURE: Wm. H. Johnson 428.0
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Gish Funeral Home Naylor, Mo.

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
FEB 4 1953
BUTLER CO. HEALTH CENTER
FILE No. 253-52

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by .....

..... , Student Embalmer No. .....

working under my personal supervision.

Student .....
Student Embalmer

Signed Bryan McCord

Licensed Embalmer No. 4079

P. O. Address Naylor Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.